

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43163

State File No. 11053

FILED JAN 10 1952

BIRTH NO. 72475-51 REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		
d. FULL NAME OF HOSPITAL OR INSTITUTION 5115 Enright ave			d. STREET ADDRESS (If rural, give location) 5115 Enright ave		
3. NAME OF DECEASED (Type or Print) Deborah		a. (First) Rachel		c. (Last) Martin	
4. DATE OF DEATH Dec 13 1951		5. SEX MF		6. COLOR OR RACE Col	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) (1)		8. DATE OF BIRTH Oct 5- 1951		9. AGE (In years last birthday) 2 2 8	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY Nil		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U-S-A.		13a. FATHER'S NAME Ramon Martin		13b. MOTHER'S MAIDEN NAME Gladys Jones	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Gladys Marton		ADDRESS 5115 Enright Ave			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc.: It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Brauche Pneumonia</i>					
DUE TO (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 491X	
22. I hereby certify that I attended the deceased from 19 to 19, that I last saw the deceased alive on 19, and that death occurred at 630 A m., from the causes and on the date stated above.					
23a. SIGNATURE Patrick E. Taylor, Cor.		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 12.14.51	
24a. DATE OF REMOVAL (Specify) Dec-15-51		24c. NAME OF CEMETERY OR CREMATORY Greenwood Cem		24d. LOCATION (City, town, or county) (State) St. Louis Co Mo	
DATE REC'D BY LOCAL REG. REG 1 1952		REGISTRAR'S SIGNATURE Paul Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE J.W. Hughes 2626 Lawton	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed *not embalmed*

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.